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This study was performed to determine the feasibility of implementing the Joint Health Benefits Deli very Program (Civilian Care) in Obstetrics or Psychiatry at Kenner Army Community Hospital. In conclusion the paper found that the comparison of inpatient civilian facility and Kenner Army Community Hospital indicated that utilization of the Joint Health Benefits Delivery Program as a mechanism for government cost sa ings would be a viable and cost effective option both for obstetrical and psychiatric services.

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A STUDY TO DETERMINE THE FEASIBILITY OF IMPLEMENTING THE JOINT HEALTH BENEFITS DELIVERY PROGRAM IN OBSTETRICS OR PSYCHIATRY AT KENNER ARMY COMMUNITY HOSPITAL

A Graduate Research Project

Submitted to the Faculty of

Baylor University

in Partial Fulfillment of the

Requirements for the Degree

of

Master of Health Administration

by

Captain Dorene Hurt, MSC

July 1986

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I. INTRODUCTION

The Joint Health Benefits Delivery Program (JHBDP) is a voluntary program established by the Department of Defense in January 1983 to assists Commanders in obtaining additional health care providers in medical treatment facilities. The primary objectives are to maximize the resources of the facility and reduce the cost of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Approximately 90,000 active duty personnel, Civilian Health and Medical Program of the Uniformed Services beneficiaries, and eligible civilians are located in the sixty-seven counties which make up Kenner Army Community Hospital's health service area.[1] According to the November 1985 MEDDAC Comptroller's Population Supported Report, of the approximately 90,000 potential beneficiaries 9865 were active duty, 19,585 retirees, 3785 active duty family members living on post, 4456 active duty family members living off post, 41,325 family members of retirees and 10,312 civilians.[2] Civilians are only counted as beneficiaries inasmuch as they are eligible for emergency care, occupational health services and to participate or benefit from some community health service programs.

Kenner Army Community Hospital experienced steady increases in the amount of funds expended to provide obstetrical and psychiatric services to its beneficiaries in fiscal years 1984 and 1985. The greatest percentage of fund expenditures, excluding personnel costs were for psychiatric and obstetrical services. Obstetrical and psychiatric services were being provided for active duty personnel via the Supplemental Care Program and via Civilian Health and Medical Program of the Uniformed Services for nonactive duty patients. Medicare eligible patients received care at Kenner Army Community Hospital

based on the availability of resources and in civilian facilities through self-pay, supplemental insurance arrangements, or the Medicare program.

Another factor which prompted the study was the opportunity to maximize the utilization of available space on the third floor of the facility (Appendix A). Having previously served as the obstetrical ward and newborn nursery prior to the termination of obstetrical services in 1976, the area has been occupied by Red Cross Volunteers, the Nursing, Education, and Training Office, the housekeeping Contracting Officer's Representative, and utilized for storage.

In an effort to maximize resources and reduce patient care costs in obstetrical or psychiatric services the executive management at Kenner Army Community Hospital requested that research be conducted to determine the feasibility of implementing the Joint Health Benefits Delivery Program in obstetrics or psychiatry, with particular emphasis on cost efficiency, effectiveness, and patient participation.

Joint Health Benefits Delivery Program

BACKGROUND

The Joint Health Benefits Delivery Program (JHBDP) is a Department of Defense (DOD) directed program established on 10 January 1983 IAW DoD 6010.12. The purpose of the program is to integrate specific OCivilian Health and Medical Program of the Uniformed Services and medical treatment facility (MTF) resources by allowing Defense Eligibility Enrollment System (DEERS) enrolled Civilian Health and Medical Program of the Uniformed Services beneficiaries to receive inpatient related outpatient services, inpatient medical care, and ambulatory care surgery services from contracted civilian health care providers with military medical treatment facility privileges.[3] Implemented

by the medical treatment facility Commander, the Joint Health Benefits Delivery Program objectives include reducing Civilian Health and Medical Program of the Uniformed Services costs, providing medical services that would otherwise be unavailable in the medical treatment facility, improving medical treatment facility productivity, increasing Civilian Health and Medical Program of the Uniformed Services beneficiary use of medical treatment facilities and assisting in the overall Department of Defense cost containment effort.

Under the program the health care provider establishes a contract with the hospital to provide inpatient services to Civilian Health and Medical Program of the Uniformed Services beneficiaries after negotiating and approval of a fee schedule and procedures listing with the Office of the Civilian Health and Medical Program of the Uniformed Services. An example of a provider - medical treatment facility contract is at Appendix A. The provider will not receive more than the Civilian Health and Medical Program of the Uniformed Services allowable charge. Outpatient services are part of the program only if directly related to inpatient care. The provider is paid by Civilian Health and Medical Program of the Uniformed Services under the standard Civilian Health and Medical Program of the Uniformed Services requirements and regulations. Under Civilian Health and Medical Program of the Uniformed Services, the patient must pay his or her cost share.[4] This is true even though the care is provided in a military hospital. Civilian Health and Medical Program of the Uniformed Services beneficiaries with supplemental insurance or a major medical insurance plan such as Blue Cross/Blue Shield will usually avoid any cost share charges. In any event, the provider bills the insurance plan first since Civilian Health and Medical Program of the Uniformed Services pays after all other plans have been utilized. Additionally, the yearly $50.00 Civilian Health and Medical Program of the Uniformed Services deductible must be paid to the provider before

Civilian Health and Medical Program of the Uniformed Services pays. Civilian Health and Medical Program of the Uniformed Services documents and assistance are available through coordination with the medical treatment facility's primary point of contact for Civilian Health and Medical Program of the Uniformed Services: the health benefits advisor.

Prospective Joint Health Benefits Delivery Program providers must be credentialed in accordance with Army Regulation 40-66 with a comprehensive privilege delineation recommendation from the Credentials Committee to the Commander prior to the implementation of a contract between the medical treatment facility and the provider.[5] Once approved by the Commander, the delineation of privileges will be signed by both parties and become an attachment to the contract or Memorandum of Understanding (MOU). Periodic review of the Joint Health Benefits Delivery Program's performance will be accomplished in the same manner that all providers are reviewed in accordance with applicable regulations and command policies.

Joint Health Benefits Delivery Program Benefits and Limitations.

If the service is available through the Joint Health Benefits Delivery Program, the Civilian Health and Medical Program of the Uniformed Services beneficiary does not have to seek care in the civilian community, pay a cost share to the hospital, or pay for ancillary services. Out-of-pocket physician costs to the patient should be reduced as the provider has the full use of ancillary services, clerical support, and medical support staff, such as licensed nurses. Examples of cost avoidance fees include physical therapy, laboratory tests, radiological tests and procedures, dressings, casts, and respiratory services.

Limitations of the program are primarily based on the medical treatment facility's resources and the contractual arrangement that is established between the provider and the hospital. The major limitation, which is perceived by HSC and Commanders as a negative aspect of the program, is the ineligibility of active duty service members. Only personnel who are Civilian Health and Medical Program of the Uniformed Services eligible are permitted to participate in the Joint Health Benefits Delivery Program.

Inpatient Cost share provisions of the Joint Health Benefits Delivery Program are as follows:

Active duty family member - no fee to provider; $7.30 per day to the medical treatment facility for subsistence.

Retired family member - 25% of the allowable charge to provider; $7.30 per day to the medical treatment facility for subsistence.

Retiree (enlisted) - 25% of the allowable charge to provider; no subsistence fee.

Retiree (officer) - 25% of the allowable charge to the provider; $7.30 per day to the medical treatment facility for subsistence.

There is no yearly deductible requirement for inpatient care in a military facility, which almost always includes surgery, and there is no $25.00 minimum fee, as is required under the standard Civilian Health and Medical Program of the Uniformed Services program. The $25.00 minimum fee and yearly deductible waiver for inpatient services are considered special program benefits.

Under the Civilian Health and Medical Program of the Uniformed Services Program, a beneficiary is responsible for the first $50.00 of Civilian Health and Medical Program of the Uniformed Services-determined reasonable costs/charges for covered outpatient services and supplies during any fiscal year. The total outpatient deductible amount for

two or more beneficiary members of the same family who submit claims during the same fiscal year is $100.00. Civilian Health and Medical Program of the Uniformed Services pays 80 percent of the Civilian Health and Medical Program of the Uniformed Services-determined reasonable charges received by spouses and children of active duty members after the deductible has been met. The beneficiaries are responsible for the remaining 20 percent. Civilian Health and Medical Program of the Uniformed Services pays 75 percent of the Civilian Health and Medical Program of the Uniformed Services-determined reasonable charges received by retirees, spouses and children of retirees, spouses and children of deceased active duty members, and spouses and children of deceased retirees. The beneficiary is responsible for the remaining 25 percent.

Although numerous Joint Health Benefits Delivery Program changes are expected as the program develops in the outpatient services area, current policy includes a major limitation. Patients who receive outpatient care in the medical treatment facility by a Joint Health Benefits Delivery Program physician cannot receive inpatient care by the same physician since that provider is not permitted to refer patients to him or herself. The impact of the current policy is twofold. First, continuity of care can be compromised when the provider most aware of the patients' needs is not permitted to participate in inpatient care, even though qualified and available. Secondly, active duty military and Department of the Army civilian physicians have to screen patients for Joint Health Benefits Delivery Program providers to ensure that only those requiring inpatient services are seen by the Joint Health Benefits Delivery Program physician on an outpatient basis.

Recommended changes to the current policy include the contracting of a Joint Health Benefits Delivery Program provider under two simultaneous contracts. Under the Direct Health Care Provider Program a physician is retained under a personal services

contract to provide services to all beneficiaries. Such a change would eliminate the restriction of Joint Health Benefits Delivery Program providers being permitted to provide outpatient services in an medical treatment facility. Screening by military and civilian physicians for the Joint Health Benefits Delivery Program physician would also no longer be necessary.

Research Objectives, Criteria, Assumptions, and Limitations

Objectives

1. Review the documentation that was used to establish at least two Joint Health Benefits Delivery Program programs within Department of Defense (Ft Eustis and Portsmouth Naval Medical Center).

2. Collect beneficiary demographic data to determine the size and characteristics of the population of concern.

3. Determine what psychiatric and obstetrical procedures or medical care the beneficiaries are receiving via Civilian Health and Medical Program of the Uniformed Services.

4. Ascertain the Civilian Health and Medical Program of the Uniformed Services reimbursement rate for proposed-inpatient services when received in a civilian medical treatment facility. Determine the cost of the same services at Kenner Army Community Hospital.

5. Analyze cost data by comparing the cost of providing services under the Civilian Health and Medical Program of the Uniformed Services Program and the Joint Health Benefits Delivery Program.

6. Determine the appropriate staffing level for psychiatric and obstetrical services under the Joint Health Benefits Delivery Program.

7. Determine the additional facility and equipment requirements if psychiatric or obstetrical services are provided under the Joint Health Benefits Delivery Program.

8. Ascertain the impact of proposed Civilian Health and Medical Program of the Uniformed Services reforms on the Joint Health Benefits Delivery Program.

9. Present findings to the Command with recommendations.

Criteria

1. The cost of providing the service under the Joint Health Benefits Delivery Program must be less than the cost of inpatient or ambulatory surgery care in a civilian health care facility utilizing the standard Civilian Health and Medical Program of the Uniformed Services Program.

2. Services to be considered under the program cannot require the construction of a separate facility.

Assumptions

1. Demographics of the Kenner Army Community Hospital catchment area will not significantly change.

2. No mission changes affecting Civilian Health and Medical Program of the Uniformed Services beneficiaries will occur during the research period.

3. The medical treatment facility must not currently provide the psychiatric and obstetrical mission authorized services under consideration. Mission authorized services are those services that can be provided by the medical treatment facility and are listed in Appendix P.

Limitations

1. Mission authorized and modified psychiatric and obstetrical services indicated on the Medical Department Activity's template (Appendix P) will be considered for inclusion in the proposed program.

2. Civilian Health and Medical Program of the Uniformed Services data such as Nonavailability Statement Summaries from October 1983 - September 1985 will be utilized in the study.

3. Kenner Army Community Hospital workload data from October 1983 - September 1985 will be utilized in the study.

4. The program is limited by the conditions stated in DoD 6010.12, dated 10 January 1983, and Health Services Command letter HSOP-FF HQS HSC, 26 June 1984, subject: Implementation of Joint Health Benefits Delivery Program.

5. The program only applies to those personnel eligible for Civilian Health and Medical Program of the Uniformed Services. It does not apply to active duty personnel or those persons eligible for Medicare based on age or disability.

RESEARCH METHODOLOGY

A review of the literature was accomplished by reviewing documentation from existing programs as provided by the Health Services Command Patient Administration Division office and workload and Civilian Health and Medical Program of the Uniformed Services utilization data from October 1983 -September 1985. The Civilian Health and Medical Program of the Uniformed Services beneficiary population in the catchment area was determined by examining Health Systems Agency data, Civilian Health and Medical

Program of the Uniformed Services Nonavailability Statement data and Civilian Health and Medical Program of the Uniformed Services Healthcare Summaries.

The projected cost of ancillary personnel to support the practitioner, equipment and facility costs were calculated and based upon estimates provided by the Logistics Division, Civilian Personnel Office, Personnel Division and Comptroller's Division, Patient Administration Division health care statistical data at Kenner Army Community Hospital. For the services to be recommended under the Joint Health Benefits Delivery Program, the total cost of personnel, equipment, and facility alterations should not exceed the cost of providing the service via Civilian Health and Medical Program of the Uniformed Services in a civilian facility.

Demographic and medical care data as described in the objectives was evaluated to determine the major commonalities in the population of concern and assisted in determining the types of psychiatric and obstetrical services that should be included in the Joint Health Benefits Delivery Program if it is to be implemented.

The financial feasibility of the Joint Health Benefits Delivery Program program was evaluated by comparing the Joint Health Benefits Delivery Program estimate for services at Kenner Army Community Hospital against the full Civilian Health and Medical Program of the Uniformed Services allowable costs for the same or similar service provided in a civilian health care facility. Civilian Health and Medical Program of the Uniformed Services information was indicated in the Nonavailability Statements for Health Services Command and the Health Services Command Uniform Chart of Accounts analysis of selected indicators.[6] The Joint Health Benefits Delivery Program costs must be less than the current Civilian Health and Medical Program of the Uniformed Services program costs.

Example: civilian hospital -

	Amount Billed
inpatient podiatric professional services:	$450.00
outpatient podiatric professional services:	20.00
Total	$470.00

Joint Health Benefits Delivery Program in KACH -

	Amount Billed
inpatient professional services:	$105.00
inpatient hospital services:	7.30 per diem
outpatient clinic visit:	20.00
Total	$150.00*

*The program's savings potential is primarily in inpatient service costs. Outpatient fees are charged patients at the normal Civilian Health and Medical Program of the Uniformed Services reimbursement rate for outpatient services. The above example is of an actual Civilian Health and Medical Program of the Uniformed Services patient bill (Appendix B and C).

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[1]Medical Department Activity, "Comptroller's Population Supported Report, Fort Lee, Virginia, November 1985.

[2]Ibid.

[3]U.S., Department of Defense Instruction, Joint Health Benefits Delivery Program, No. 6010.12, February, 1983, pp. 1-6.

[4]U.S., Department of Defense, CHAMPUS Handbook, No. 6010.46-H, Aurora, Colorado, 1985, pp 10-16.

[5]U.S., Department of the Army Headquarters, United States Health Services Command, Implementation of Joint Health Benefits Delivery Program, June, 1984, pp. 1-8.

[6]U.S., Department of the Army, Office of The Surgeon General, Medical Summary Report - Section IV, Nonavailability Statements, (MED 302, R-3), October 1984 - September 1985, pp. 1-10.

II. JOINT HEALTH BENEFITS DELIVERY PROGRAM LITERATURE AND PROGRAM REVIEW

General

Joint Health Benefits Delivery Program literature and program reviews were performed based upon available information since the program's February 1983 authorization. Given the newness of the program, a historical literature base primarily consisted of Department of Defense, Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) and Health Services Command program justification and implementation guidelines. The overall program objective was to provide medical treatment facility Commanders a mechanism for providing services which would otherwise be unavailable to Civilian Health and Medical Program of the Uniformed Services beneficiaries in a military facility. Simultaneously, significant savings in Civilian Health and Medical Program of the Uniformed Services fund expenditures were anticipated. The Office of the Civilian Health and Medical Program of the Uniformed Services has been tasked to provide statistical, pecuniary, program performance and utilization data to the Office of the Assistant Secretary of Defense for Health Affairs on an ongoing basis. Information found in recently published Civilian Health and Medical Program of the Uniformed Services program literature and discussions during Health Benefits Advisor Conferences indicate that sweeping changes within Civilian Health and Medical Program of the Uniformed Services are imminent due to consistently increasing Civilian Health and Medical Program of the Uniformed Services costs.[1] Regulated by Civilian Health and Medical Program of the Uniformed Services policy, the Joint Health

Benefits Delivery Program could be affected by any change. Navy, Air Force and Army medical treatment facility Commanders have introduced the program sparingly. A review of the literature revealed that podiatric, otorhinolargyngology, and urologic services comprised the bulk of Joint Health Benefits Delivery Program that were proposed or functioning.[2]

Headquarters, Health Services Command retained the approval authority for all Army-proposed Joint Health Benefits Delivery Program arrangements. Upon expiration of agreements, renewal requests must also be forwarded for consideration to Headquarters, Health Services Command.

Reviews of Joint Health Benefits Delivery Program related documents were physically accomplished at Portsmouth Naval Medical Center and McDonald Army Community Hospital, Fort Eustis, Virginia. An overview of each facility's current program was provided by the respective Health Benefits Advisor. Information specifying the development, execution and overall administration of each program was obtained. Additionally, other Joint Health Benefits Delivery Program reviews were conducted through examination of documentation for Joint Health Benefits Delivery Program's at the Forts Devens, Leavenworth, Benjamin Harrison and Sill community hospitals and Fitzsimons Army Medical Center.

Portsmouth Naval Medical Center

As of the beginning of the 1986 fiscal year Portsmouth Naval Medical Center was a training hospital with over 500 beds and a beneficiary population of approximately 292,373 in its catchment area. The distribution of the beneficiaries by category is indicated in Appendix D. Overall trends in the population indicated a steady growth in dependents of active duty and dependents of retired categories during the last four years.

Vascular surgery needs that were previously performed under Civilian Health and Medical Program of the Uniformed Services were steadily increasing and absorbing significant amounts of both Civilian Health and Medical Program of the Uniformed Services and supplemental care monies. A vascular surgery Joint Health Benefits Delivery Program was recommended by several key medical staff members as a way to reduce supplemental care and Civilian Health and Medical Program of the Uniformed Services monies expended, assist beneficiaries by reducing their cost share, and take advantage of the opportunity for interns and residents to observe vascular surgery techniques. The hospital commander approved the request and subsequently assigned coordinating responsibilities to the fiscal officer.

Portsmouth Naval Hospital implemented a Joint Health Benefits Delivery Program for vascular surgery in November 1985. The hospital's fiscal officer was the primary coordinator for the program. Although the Health Benefits Advisor and Patient Administration Department are jointly responsible for the administrative and organizational requirements of a Joint Health Benefits Delivery Program, neither area informed of the program until February 1986. It was at this time that patient and sponsor inquiries concerning the reason for patient billing and queries about proper administrative and billing procedures from the vascular surgeons were received. Formal notification to the Health Benefits Advisor was not accomplished until March 1986, at which time a copy of the Provider Agreements were received, including a Civilian Health and Medical Program of the Uniformed Services-approved negotiated fee schedule signed by the three participating health care providers and the Commanding Officer of the Portsmouth Naval Medical Center on 15 November 1985 (Appendix C). Delays in the involvement of the Patient Administration Department in general, and the Health Benefits Advisor in particular, consistently resulted in numerous complaints from patients who had received vascular surgery services but had not been or only partially briefed on the Joint Health

Benefits Delivery Program. Numerous complaints relative to payment delays were also received from the three participating vascular surgeons. Several vascular surgery patient billings were subsequently cancelled and the costs absorbed due to the Naval Medical Center's absence of a comprehensive, well planned and advertised policy on the Joint Health Benefits Delivery Program. Inspector General inquiries and participating physician complaints about many vascular surgery procedures performed from November 1985 to March 1986 were still pending action in June 1986.

Coordination between the fiscal officer and Patient Administration Department began in March 1986. The objective of the concerted effort was to properly plan the implementation of the Joint Health Benefits Delivery Program as prescribed by the DoD directive. Although no additional resources in terms of personnel, space, or equipment were to be made available to the Patient Administration Department, a planned, coordinated program was expected to positively facilitate the accomplishment of all documentation and reimbursement requirements. Initial actions included: careful review of the negotiated agreement with the three vascular surgeons, briefing the program's regulatory requirements to key hopsital personnel and participating providers, marketing the program throughout the Medical Center and local media, and establishment of administrative procedures to be followed when vascular surgery patients were treated under the Joint Health Benefits Delivery Program. Development of a form which briefly explained the program and treatment arrangements was quickly accomplished, then distributed for use (Appendix E). Responsibility for briefing potential patients was initially assigned to the affected departments. Patients were then supposed to be directed to the Health Benefits Advisor after signing the form for further explanation and completion of required Civilian Health and Medical Program of the Uniformed Services' documents. Regular failures in referring patients to the Health Benefits Advisor indicated a need for the Health Benefits Advisor to establish a procedure for periodic

checking of department records. Periodic checks to balance the records and discover inconsistencies became effective program administration tools and resulted in significantly fewer complaints or regulatory omissions.

Costly lessons were learned by the providers and administrators of the Joint Health Benefits Delivery Program at Portsmouth Naval Medical Center. Coordinated staff planning, command awareness and patient awareness were admittedly lacking prior to program implementation. Additional services are being identified and expected to be provided under the Joint Health Benefits Delivery Program at Portsmouth Naval Medical Center after patient and documentation proficiency is demonstrated using currrently established policies and procedures.

McDonald Army Community Hospital

Podiatric services became available at McDonald Army Community Hospital, Fort Eustis, Virginia, under the Joint Health Benefits Delivery Program in October 1985. Contract agreement provisions approved by the Office of the Civilian Health and Medical Program of the Uniformed Services and signed by the provider and the hospital commander are at Appendix E. Major conditions of the contract include: a Virginia State licensure requirement, personal liability coverage, clinical privilege application and approval, adherence to Civilian Health and Medical Program of the Uniformed Services allowable payment policies and the Health Care Provider Agreement.

Prior to the effective date of the programs, McDonald Army Community Hospital notified beneficiaries of the new program through the media, handouts, and presentations to the Fort Eustis active duty and retired communities (Appendix G and H). No additional resources were provided to the Health Benefits Advisor who was tasked as primary coordinator of documentation completion. Non-active duty patients requiring podiatric

services were routinely given an information paper which explained the Joint Health Benefits Delivery Program. Potential patients were given the option to participate in the voluntary program or receive a Statement of Nonavailability. A Statement of Nonavailability enabled the beneficiary to seek care under the standard Civilian Health and Medical Program of the Uniformed Services guidelines. If the patient elected to receive care at McDonald Army Community Hospital, patient data and contract documents which further clarified the program were completed in the department (Appendix I and J). Subsequent referral to the Health Benefits Advisor permitted expeditious processing of Civilian Health and Medical Program of the Uniformed Services forms.

Podiatric services were limited by the provisions of the contract and approved services covered under the Civilian Health and Medical Program of the Uniformed Services. Routine foot care by a podiatrist could be a Civilian Health and Medical Program of the Uniformed Services benefit if the patient had a diagnosis of a systemic disease that had resulted in a severe circulatory deficiency or desensitization of areas in the legs or feet. Covered services would include cutting or removal of corns, calluses or nails (Appendix K). Thorough documentation on the claim form was necessary to determine the medical necessity of the service(s). Identification of any systemic disease, symptoms or physical findings to establish the severity of the disease was critical. Generally, the existence of the following conditions permitted payment for routine foot care under the Civilian Health and Medical Program of the Uniformed Services: diabetis mellitus, chronic thrombophlebitis and peripheral neuropathies involving the feet. One hundred ninety-one approved procedures with associated fees were listed in the provider contract. Procedures were based on the Physician's Current Procedural Terminology Manual Codes (Enclosure F).

Program administration concerns developed as utilization of podiatric services increased. Numerous issues regarding appropriate provider activities were raised by the provider from the contracts inception. In the absence of definitive guidance the provider began several questionable practices. Self-referrals were made in direct conflict with the contract. Charges in excess of negotiated fees were continuously discovered (Enclosure C and L). Coupons covering the annual deductible were made available to potential patients. Departmental difficulties in monitoring one hundred ninety-one approved procedures were realized. The provider was only scheduled to provide podiatric services one to two days each week. Continuity of inpatient care and risk management became serious concerns. To compound the problem, the provider treated all eligible patients, including active duty members, one day per week while on active duty as a reservist. An audit of the entire program emphasizing the legal and ethical appropriateness of the provider was ongoing as of June 1986. Payment for completed procedures was also delayed pending completion of an audit by the Office of the Civilian Health and Medical Program of the Uniformed Services. Joint Health Benefits Delivery Program limitations and administrative concerns has prompted McDonald Army Community Hospital to delay further program changes until resolution of current issues and an increase in resources to adequately support the program.

Additional Joint Health Benefits Delivery Program Reviews

Cutler Army Community Hospital, Fort Devens, Massachusetts initially instituted a Joint Health Benefits Delivery Program with two physicians for allergy/ears-nose-throat and urology services. Inpatient surgery was generated from urology services. Administrative responsibilities vary based on the facility. Cutler Army Community Hospital elected to change one of the two Civilian Health and Medical Program of the

Uniformed Services office positions permanently upon activation of the program and the subsequent increase in workload. Health Benefit Advisors trained clinic secretaries and receptionists in locations where Joint Health Benefits Delivery Program providers practiced to issue and complete forms for patients. After the patient was seen by the participating provider and completed the necessary forms, he or she was sent to the Health Benefits Advisor for counseling. Flyers explaining the Joint Health Benefits Delivery Program were in all clinics regardless of participation. Although expected to decrease, Nonavailability Statement issuance did not decrease in the areas where Joint Health Benefits Delivery Program providers were available. Problems in administration and payment authorization have been encountered with the Civilian Health and Medical Program of the Uniformed Services fiscal intermediary. Since the ENT physician was not charging the agreed upon charge, no fee was paid at all by Civilian Health and Medical Program of the Uniformed Services. The physician has since departed. Cost shares paid by patients have not presented a problem thus far. Plans were being made to further reduce the program instead of expanding due to Command's perception that Joint Health Benefits Delivery Program problems outweighed the benefits derived from it and the absence of a reduction in the overall Civilian Health and Medical Program of the Uniformed Services cost.

Fitzsimons Army Medical Center, Aurora, Colorado had four pediatricians contracted under the Joint Health Benefits Delivery Program. The inpatient pediatric workload has increased due to the addition of the four pediatricians. Nonavailability Statements were primarily issued for cardiology services. Most services were being provided at the Medical Center. After an initial consultation and completion of the physician's portion of the Civilian Health and Medical Program of the Uniformed Services form in the department, patients were briefed by the Health Benefits Advisor who

assisted in completing the remainder of the forms. No particular problems were reported or documented. The Office of the Civilian Health and Medical Program of the Uniformed Services is conveniently located on the grounds of the Medical Center.

Munson Army Community Hospital located at Fort Leavenworth, Kansas, is a 50-bed acute care hospital. Two surgeons were contracted under the Joint Health Benefits Delivery Program, each served one day per week. Inpatient and ambulatory surgery was performed after eligible patient referrals. No outpatient care was provided. Two General Schedule-7 employees accomplished duties in the Civilian Health and Medical Program of the Uniformed Services Office. Although the workload increased, no additional resources were allocated for administration of the program. Patients were sent to the Health Benefits Advisor for counseling and presentation of available alternatives. Unlike most facilities reviewed, the Health Benefits Advisor had the physician's fee schedule to make patients aware of the expected cost share amount prior to surgery. After counseling, physicians confirm surgery case(s) with the Health Benefits Advisor. After surgery, the Health Benefits Advisor completes the Civilian Health and Medical Program of the Uniformed Services form which the physicians sign. Ledgers were being kept on all Joint Health Benefits Delivery Program patients by the surgeons. No plans for program expansion were anticipated.

Joint Health Benefits Delivery Program's have been in effect at Hawley Army Hospital, Fort Benjamin Harrison, for one year. Three general surgeons and one podiatrist were contracted under the program. Verbal approval to expand the program by adding an orthopedist had been received. On a non-recurring basis, Joint Health Benefits Delivery Program providers saw active duty patients, but were paid out of supplemental care funds. Civilian Health and Medical Program of the Uniformed Services' workload increased causing another individual to be assigned to assist the Health Benefits Advisor as a

collateral duty. Participating physicians were negligent in their responsibility to obtain their cost share from the patient. Concomitant problems were a result, specifically, total processing delays. Program expansion was planned although the specialty area had not been identified.

A 225-bed acute care facility, Reynolds Army Community Hospital is located at Fort Sill, Oklahoma. One ENT provider was operating under the Joint Health Benefits Delivery Program to provide inpatient surgery. Active personnel were also seen under the provisions of a personal services contract. Nonavailability Statement issuance has not decreased since the start of the program; approximately 30 were processed each month. Health Benefits Advisors complete a portion of the Civilian Health and Medical Program of the Uniformed Services form following patient counseling. The physician completes the remainder of the document upon completion of the procedure. Even though a list of procedures and fees were retained by the Health Benefits Advisor, the physician elected to apply the Current Procedural Terminology Manual. Future expansion will be dependent upon the benefits of the curent program.

The commonality in each program review was the lack of planning or plans which anticipated problems experienced. Several programs were initiated prior to any documented plan, utilizing verbal directives instead. Facility or financial limitations and active command involvement consistently prevented adequate Civilian Health and Medical Program of the Uniformed Services office staffing, information dissemination and internal program support. Scant or no guidance from the office of the Civilian Health and Medical Program of the Uniformed Services yielded little in problem resolution or program establishment.

Positively, Joint Health Benefits Delivery Program administrators were attempting to make the program productive through internal coordination with staff and external coordination with fiscal intermediaries, field representatives, major commands and the Office of the Civilian Health and Medical Program of the Uniformed Services.

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[1]U.S., Department of Defense, Office of the Assistant Secretary of Defense for Health Affairs, Fact Sheet: CHAMPUS Reform Initiative, September 1985, pp. 1-4.

[2]U.S., Department of the Army, United States Army Health Services Command Biostatistical Activity, Nonavailability Statements Summary for Health Services Command, March 1985, pp. 1-9.

III. PSYCHIATRIC SERVICE

Kenner Army Community Hospital does provide outpatient services, but does not operate an inpatient psychiatric service in accordance with the Mission Authorization List (Enclosure O). The two military psychiatrists currently assigned to the Medical Department Activity are responsible for providing outpatient services in the Community Mental Health Activity. Acute psychiatric patients are periodically admitted as inpatients into medical beds until stabilized. 140 and 139 nonavailability statements were issued for psychiatric services in fiscal years 1984 and 1985, respectively, at a cost of $1,898,782.00 for 1984 and $1,787,267 for 1985 (Enclosure M and N). Fifty percent of the nonavailability statements were issued for services provided to adolescents. Civilian Health and Medical Program of the Uniformed Services health care summary data categorizes psychiatric services by groups. Group 1 psychiatric codes according to diagnosis are listed in Table 1. Group 2 psychiatric codes are listed in Table 2. Psychiatric diagnoses not listed within either psychiatric group are not presently provided for under the Civilian Health and Medical Program of the Uniformed Services regulations.[1]

Inpatient Psychiatric Service Estimate

Staffing requirements, nutrition care, supply expenses, and anticipated equipment needs could be fulfilled for a total first year cost of $589,279.40 as reflected in Tables 3, 4, and 5. An analysis of the data indicates that an inpatient psychiatric ward could be established for an estimated cost of $595,983.40 the first fiscal year.

TABLE 1

PSYCHIATRY CODES ACCORDING TO DIAGNOSIS

PSYCHIATRY GROUP I (19)

290	SENILE AND PRESENILE DEMENTIA
291	ALCOHOLIC PSYCHOSIS
292	PSYCHOSIS ASSOCIATED WITH INTRACRANIAL INFECTION
293	PSYCHOSIS ASSOCIATED WITH OTHER CEREBRAL CONDITIONS
294	PSYCHOSIS ASSOCIATED WITH OTHER PHYSICAL CONDITIONS
295	SCHIZOPHRENIA
296	ACTIVE PSYCHOSIS
297	PARANOID STATES
298	OTHER PSYCHOSIS
299	UNSPECIFIED PSYCHOSIS
300	NEUROSES
301	PERSONALITY DISORDERS
305	PHYSICAL DISORDERS OF PRESUMABLE PSYCHOGENIC ORIGIN
309	MENTAL DISORDERS NOT SPECIFIED AS PSYCHOTIC ASSOCIATED WITH PHYSICAL CONDITIONS

TABLE 2

PSYCHIATRY CODES ACCORDING TO DIAGNOSIS

PSYCHIATRY GROUP II (20)

302	SEXUAL DEVIATION
303	ALCOHOLISM
304	DRUG DEPENDENCE
306	SPECIAL SYMPTOMS NOT ELSEWHERE CLASSIFIED
307	TRANSIENT SITUATIONAL DISTURBANCES
Y13	SOCIAL MALADJUSTMENT

TABLE 3

INPATIENT PSYCHIATRIC WARD STAFFING ESTIMATE

*OIC/Supervisory (Psychiatric Nurse)	MAJ	Annual $64,146	$64,146
or	GS12	31,619	
*Clinical Psychiatric Nurse	CPT	51,419	
or	GS9	21,804	21,804
NCOIC/Wardmaster	E7	35,684	35,684
	GS5	14,390	14,390
Licensed PracticalNurse/91F	E6	30,224	30,224
or	GS 5/1	14,390 x 5	71,950
*Social Worker	CPT	51,419	
or Social Worker with Drug/ Alcohol Program experience	GS 11/1	26,381	26,381
Occupational/Recreational Therapist	CPT	51,419	51,419
and Occupational Therapist Specialist	GS 5/1	14,390	14,390
Physical Therapist	CPT	51,419	51,419
and	GS 5/1	14,390	14,390
*Ward Clerk	E4	21,686	
or	GS 4/1	12,862	12,862
Psychologist	GS 12/1	Hour $15.15 x 8 hours $121.20 x 52 weeks	6,302.40
Psychiatrist	GS 13/1 at 20 hrs/week	Annual $37,599	37,599
		TOTAL	$452,960.40

NOTE 1: Civilian annual salaries are based on the grade and first step. Military pay is based on military standard composite.

NOTE 2: Staff positions annotated with an asterisk were selected based on Command preference. Civilian staffing was generally preferred for continuity of care and minimization of salary costs.

TABLE 4

ESTIMATED SUPPLY EXPENSES FOR PSYCHIATRIC WARD
(FIRST YEAR)

Linen (Nonconsumable)	$2,791.00
Linen (Consumable)	900.00
Draperies (Disposable)	4,826.00
Self Service Supply Center (Administrative) Supplies	1,600.00
Miscellaneous (Shelving, Paintings, Trash Cans, Blank tapes)	2,800.00
Medical Supplies	7,000.00
TOTAL	$19,917.00

TABLE 5

EQUIPMENT ESTIMATE FOR PSYCHIATRIC WARD

NOMENCLATURE	QTY	U/P	TOTAL PRICE
Cart Linen, Small	2	$ 900.00	$ 1;800.00
Cart Linen, Large	1	1,200.00	1,200.00
Cart Wire, 24" x 60"	2	600.00	1,200.00
Cart Wire, 30" x 60" x 65"	2	700.00	1,400.00
Nourishment Station	1	12,000.00	12,000.00
Refrigerator, Drug	1	300.00	300.00
VCR	1	500.00	500.00
Monitor for VCR	1	350.00	350.00
Intercom System	1	300.00	300.00
Console for VCR and Monitor	1	600.00	600.00
Desk Sgl Ped	1	275.00	275.00
Desk Dbl Ped	8	350.00	350.00
Chair Rotary w/Arms	9	175.00	350.00
Cabinet Filing, 4 Drw	4	175.00	175.00
Refrigerator, 3 cu ft	2	175.00	350.00
Hide-A-Bed	1	350.00	350.00
Chair, Patient	18	150.00	2,700.00
Television, Color, 25 inch	2	450.00	900.00
Chair, Convertible to Bed	1	450.00	450.00
Chair, Stacking	15	150.00	2,250.00
Chair, Padded	15	150.00	2,250.00
Coffee Pot	1	25.00	25.00
Tape Recorder	1	200.00	200.00
Rack Magazine	3	160.00	480.00
Chair, Reclining	2	300.00	600.00
Typewriter	1	750.00	750.00
Embossing Machine	1	450.00	450.00
Bed Hospital, w/Mattress	10	1,600.00	16,000.00
Thermometer, IVAC	3	350.00	1,050.00
Clinical Scale	1	250.00	250.00

NOMENCLATURE	QTY	U/P	TOTAL PRICE
Lamp, Table	5	$ 75.00	$ 375.00
Bedside Cabinet	10	120.00	1,200.00
Overbed Table	10	150.00	1,500.00
Cabinet, Medicine	1	660.00	660.00
Cart, Chart	1	300.00	300.00
Occupational Therapy Arts and Crafts Set	2	95.00	180.00
Crash Cart, 5 Drawer	1	850.00	850.00
Nurse Call System	6	5,200.00	31,200.00
Conference Room Table	1	500.00	500.00
Carpet at $11.50 square yard	20 yds	11.50	230.00
		TOTAL	$86,850.00

NOTE: Equipment estimates were provided by the Logistics Division.

The estimated costs of physically transforming the available ward into an inpatient psychiatric ward are shown in Table 6. Costs were based on historical Civilian Health and Medical Program of the Uniformed Services workload, actual personnel costs and estimated logistical requirements. Fixed costs and available costs, particularly base support engineer and logistical services were not maintained in a manner which permitted an estimation of Kenner Army Community Hospital costs.

Special Considerations

Inpatient psychiatric services traditionally require large numbers of trained personnel to provide quality services as compared to other inpatient services, such as medical-surgical wards, which conversely have more equipment requirements.[2] According to the Deputy Commander for Clinical Services at Kenner Army Community Hospital, several administrators and practitioners in area psychiatric hospitals and the literature, the baseline services that should be provided in a ten-bed psychiatric ward are psychological testing, social work services, drug and alcohol rehabilitation services, psychotherapy, psychometrics and general psychiatry. Customary ancillary services include radiological, laboratory, electrocardiogram, electroencephlogram and pharmaceutical services.[3]

Civilian Health and Medical Program of the Uniformed Services policies provide directives regarding the limitations of inpatient mental health care. Conditions which are covered by Civilian Health and Medical Program of the Uniformed Services include attention deficit disorders, specific developmental disorders, collateral visits which are defined as services to interpret or explain results of psychiatric, other medical examinations and procedures, other accumulated data to family or other responsible persons, or advising them on how to assist the patient.[4] Psychotherapy, crisis

TABLE 6

RENOVATION COST ESTIMATE FOR INPATIENT PSYCHIATRIC WARD

Install wall padding for an isolation room	$1800.00
Remove glass from nursing stations	900.00
Remove or cover 36 outlets in ten patient rooms	426.00
Replace glass fixtures, mirrors, and toilet fixtures with unbreakable material	1550.00
Rubberize windows in 10 patient rooms	420.00
Install nurse call system	1500.00
Install 20 yards of carpeting	100.00
TOTAL	$6704.00

intervention, social work services, and drug and alcohol rehabilitation are also reimburseable under the Civilian Health and Medical Program of the Uniformed Services program.

Restrictions on inpatient mental health care do exist in the Civilian Health and Medical Program of the Uniformed Services program. Inpatient admissions beginning on or after January 1, 1983, permit no Civilian Health and Medical Program of the Uniformed Services funds to be used for payment of institutional or professional claims for inpatient mental health services in excess of sixty days in a calendar year. The limit does not apply to the following circumstances however:

a. Any services provided under the Program for the handicapped or in a residential treatment center.

b. Any services provided as partial hospitalization, if such services are covered by Civilian Health and Medical Program of the Uniformed Services.

c. Any inpatient mental health services rendered to patients admitted before January 1, 1983, provided the patient remains continuously hospitalized and the inpatient care is medically or psychologically necessary.

d. Inpatient services beyond sixty days are covered if the Director, Civilian Health and Medical Program of the Uniformed Services, finds that the patient is suffering from an acute mental disorder or acute exacerbation of a chronic mental disorder which results in the patient being put at significant risk to self or a danger to others and the patient requires a type, level, and intensity of service that can only be provided in an inpatient setting.

e. The patient has medical complications and requires a type, level, and intensity of service that can only be provided in an inpatient setting.

f. Psychotherapy incidental to a rehabilitation stay for accident victims or a medical stay for cancer patients when the therapy is not intensive or on-going and does not contribute to the need for an inpatient stay.[5]

Comparison of Civilian Health and Medical Program of the Uniformed Services and Joint Health Benefits Delivery Program Psychiatric Service Costs

Civilian Health and Medical Program of the Uniformed Services Health Care Summary by primary diagnosis data segregates inpatient and outpatient costs by diagnosis for fiscal years 1984 and 1985. The primary area where substantial savings could be experienced utilizing the Joint Health Benefits Delivery Program instead of the standard Civilian Health and Medical Program of the Uniformed Services method was in total government inpatient and professional costs (Enclosures M and N). Significant savings could also be realized for inpatient professional and outpatient services since patients would not be charged for ancillary services as required when care was rendered in a civilian facility. Joint Health Benefits Delivery Program estimated costs and Civilian Health and Medical Program of the Uniformed Services inpatient costs for fiscal years 1984 and 1985 were compared for determination of the most cost effective and efficient program. Itemization of actual Civilian Health and Medical Program of the Uniformed Services and calculated Joint Health Benefits Delivery Program for fiscal years 1984 and 1985 inpatient costs are as indicated in Table 7.

TABLE 7

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES AND JOINT HEALTH BENEFITS DELIVERY PROGRAM PSYCHIATRY SERVICE COSTS FOR FISCAL YEARS 1984 and 1985

Civilian Health and Medical Program of the Uniformed Services Fiscal Year 1984

	Psychiatry Group 1	Psychiatry Group 2	Beneficiaries Group 1	Beneficiaries Group 2
Total Inpatient Hospital Services	$990,120	522,041 = $1,512,161	92	48 = 140
Inpatient Hospital Services Government Cost (75%)	732,311	421,654 = $1,153,965		
Inpatient Hospital Services Patient Cost (25%)	257,809	100,387 = 358,196.00		
Average Length of Stay (Days)	32.53	43.45		
Total Occupied Bed Days	3,123	1,912 = 5,035		
Total Inpatient Professional Services Cost	110,353	47,439	82	46
Total Government Cost	89,391	35,047		
Total Patient Cost	20,962	12,392		

Kenner Army Community Hospital Joint Health Benefits Delivery Program Cost

Total Psychiatric Inpatient Costs	199,664
Occupied Bed Days	797
Cost Per Bed Day	250.51

Kenner Army Community Hospital Rate applied to Civilian Health and Medical Program of the Uniformed Services Inpatient Hospital Services Government Cost of $1,512,161.00

5035 Occupied Bed Pays for 140 patients

x 250.51 cost per bed day

$1,261,317.00

$1,512,161.00 - 1,261,317.00 = $250,844.00 (Savings Potential)

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES PSYCHIATRIC CHARGES (FOR FISCAL YEAR 1985)

	Psychiatry Group 1		Psychiatry Group 1	Group 1 Beneficiaries	Group 2 Beneficiaries
Total Inpatient Hospital Services	$1,035,054	+	384,881 = 1,419,935	101	38
Inpatient Hospital Services Government Cost	748,100		272,228		
Inpatient Hospital Services Patient Cost	286,954		111,653		
Average Length of Stay (Days)	30.23		25.29		
Total Occupied Bed Days	3,325	+	1,062 = 4387		
Total Inpatient Professional Services Cost	93,754	+	45,894 = 139,648.00		
Total Government Cost	75,327		29,962		
Total Patient Cost	18,427		15,932		

Kenner Army Community Hospital Joint Health Benefits Delivery Program Cost

Total Psychiatric Inpatient Cost 223,148

Occupied Bed Days 1125

Cost Per Bed Day 198.35

Kenner Army Community Hospital Cost Applied to Civilian Health and Medical Program of the Uniformed Services Inpatient Hospital Services Government Cost of

$1,419.935

4387 Occupied bed days for 139 patients

x198.35 cost per bed day

$870,161.45

$1,419,935 - $870,161.45 = $549,773.6 (Savings potential)

Kenner Army Community Hospital data was retrieved from the Comptroller Division's Uniform Chart of Accounts historical Medical Expense Performance Report. The Civilian Health and Medical Program of the Uniformed Services fiscal year 1984 total psychiatric inpatient hospital cost was $1,512,161.00 versus a Joint Health Benefits Delivery Program estimated cost of $1,261,317.00, resulting ina $250,844.00 Civilian Health and Medical Program of the Uniformed Services potential net expenditure difference or savings. Kenner Army Community Hospital's cost per occupied bed day rates were based on an average cost. In accordance with the military's current cost accounting policies, patient bed days for any diagnosis were not distinguishable as were the costs in civilian hospitals under diagnosis related groups. Psychiatric hospitals, or hospitals with psychiatric wards, use accounting practices which establish charges based on type and amount of care received, overhead, and a revenue generating charge. For example, a surgical patient's occupied bed day rate would be identical to the rate for a patient admitted for influenza during the same fiscal year. Inpatient professional hospital psychiatric services were rendered for a total Civilian Health and Medical Program of the Uniformed Services cost of $157,792.00 for fiscal year 1984 and $139,648.00 for fiscal year 1985. Under the Joint Health Benefits Delivery Program, savings could be realized in professional services for the patient and the government. Joint Health Benefits Delivery Program providers must negotiate a fee schedule (with the Office of the Civilian Health and Medical Program of the Uniformed Services) for specified procedures prior to signing a contract with the Hospital Commander. Professional service fees have been lower for providers rendering care under the Joint Health Benefits Delivery Program in military facilities since overhead expenses, such as administrative, clerical, paraprofessionals, supplies, pharmaceuticals, physical therapy, radiology, and laboratory services, were available at no additional cost to the provider or patient.[6] Total Civilian Health and

Medical Program of the Uniformed Services inpatient professional hospital psychiatric services charges for fiscal years 1984 and 1985 could have been reduced by those associated charges. The total charge could have been reduced by the minimum $25.00 fee charged each patient when services were received in a civilian medical treatment facility. There was no yearly deductible or $25.00 minimum fee for care received in a military medical treatment facility. Subsistence and professional service rates were based on beneficiary status excluding the deductible and minimum service fee. Civilian Health and Medical Program of the Uniformed Services rates include a deductible requirement and minimum fee based on beneficiary category.

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[1]U.S., Department of Defense CHAMPUS, CHAMPUS Policy Manual, Volume II, June 1984, pp 1-5.

[2]U.S., Department of Defense CHAMPUS, CHAMPUS Policy Manual, Volume I, December, 1982, pp. 12-20.

[3]Virginia. Virginia Health Services Cost Review Commission, Interpretation and Findings: Comparison of Hospital Charges as of February 1, 1985 and Comparison of Hospital Charges by Diagnoses for the Month of February 1985, pp. 15-20.

[4]U.S., Department of Defense CHAMPUS, CHAMPUS Policy Manual, Volume II, June 1984, pp. 6-8.

[5]Ibid.

[6]U.S., Department of the Army Headquarters, United States Army Health Services Command, Implementation of Joint Health Benefits Delivery Program, June, 1984, pp. 2-5.

IV. OBSTETRICS SERVICE

Both inpatient and outpatient obstetrical services were discontinued at Kenner Army Community Hospital in 1976. Upon determination of pregnancy in the Kenner Army Community Hospital Gynecology Clinic or in a civilian facility, patients were immediately referred to the Health Benefits Advisor for Civilian Health and Medical Program of the Uniformed Services benefits counseling and to request a Statement of Nonavailability (Appendix P). Pregnant patients experiencing nonpregnancy related illnesses, such as orthopedic injuries, were infrequently admitted to Kenner Army Community Hospital during fiscal years 1984 and 1985.

Inpatient Obstetric Service Estimate

Inpatient obstetrical services for fiscal years 1984 and 1985 were provided under Civilian Health and Medical Program of the Uniformed Services for a cost of $1,381,275.00 and $1,484,095.00, respectively. Estimated costs for transforming the available ward into an inpatient obstetrical ward, nursery and labor and delivery suite is shown in Table 8. Costs were based on historical Civilian Health and Medical Program of the Uniformed Services workload, actual personnel costs and estimated logistical requirements. Base support engineer and logistical costs were not separated for estimation of overall base support expenses. Ward renovation, personnel, supplies and equipment acquisition could be accomplished for a first year cost of $1,016,702.00 (Table 8 and 9). Inpatient obstetrical and nursery services could result in an increased inpatient pediatric

TABLE 8

ESTIMATED SUPPLY EXPENSES FOR OBSTETRICS

Supply Expenses

Linen (Nonconsumable)	$ 2,791
Linen (Consumable)	900
Draperies (Disposable)	4,826
SSSC (Administration)	800
Misc (Desks, Shelving, Trash cans)	1,500
Medical Supplies	10,000
TOTAL	$20,817

Ward Renovation Expenses

Ward Upgrade	$ 9,800
Paint Ward	1,500
Replace Glass	2,800
Renovate Nurse Call	5,500
TOTAL	$39,800

OB STAFFING

LABOR/DELIVERY/POST PARTUM	RANK/ GRADE	NO. OF POSNS x	YEARLY* SALARY =	SALARY
Clinical head Nurse	MAJ	1	$66,137	$ 66,137
Clinical Nurse	GS-09	6	24,712	148,272
Wardmaster	E7	1	37,241	37,241
Licensed Practical Nurse	GS-05	5	16,310	81,550
NURSERY				
Clinical Nurse	GS-09	5	24,712	123,560
Licensed Practical Nurse	GS-05	5	16,310	81,550
TOTAL		23		$538,310

NOTE: FY 85 Composite Standard Rate for Military and FY85 GS Pay Scale, Step 5 for Cviil Service.

TABLE 9

EQUIPMENT ESTIMATE FOR OBSTETRICS WARD

NOMENCLATURE	QTY	U/P	TOTAL PRICE
Cart Linen, Small	2	$ 900.00	$ 1,800.00
Cart Linen, Large	1	1,200.00	1,200.00
Cart Wire, 24" x 60"	2	600.00	1,200.00
Cart Wire, 30" x 60" x 65"	2	700.00	1,400.00
Nourishment Station	1	12,000.00	12,000.00
Refrigerator, Drug	1	300.00	300.00
VCR	1	500.00	500.00
Monitor for VCR	1	350.00	350.00
Intercom System	1	300.00	300.00
Console for VCR & Monitor	1	600.00	600.00
Desk Sgl Ped	1	275.00	275.00
Desk Dbl Ped	1	350.00	350.00
Chair Rotary w/Arms	2	175.00	350.00
Cabinet, Filing, 4 Drawer	1	175.00	175.00
Refrigerator, 3 cu ft	2	175.00	350.00
Hide-A-Bed	1	350.00	350.00
Chair, Patient	18	150.00	2,700.00
Chair, Rocking	10	175.00	1,750.00
Chair, Convertible to Bed	1	450.00	450.00
Chair, Stacking	15	150.00	2,250.00
Chest of Drawers for Birthing Room	2	250.00	500.00
Rack Magazine	3	160.00	480.00
Chair, Reclining	2	300.00	600.00
Typewriter	1	750.00	750.00
Embossing Machine	1	450.00	450.00
Television	8	350.00	2,800.00
Bed Hospital, w/Mattress	10	1,600.00	16,000.00
Anesthesia Apparatus	1	12,000.00	12,000.00
Sphygmomanometer Electronic-Ultrasonic	2	2,000.00	4,000.00
Thermometer IVAC	3	350.00	1,050.00

NOMENCLATURE	QTY	U/P	TOTAL PRICE
Fetal Resuscitation Unit	1	$ 8,950.00	$ 8,950.00
Delivery Table	2	11,000.00	22,000.00
Clinical Scale	1	250.00	250.00
Surgical Lights	2	1,500.00	3,000.00
Bedside Cabinet	11	120.00	1,320.00
Overbed Table	11	150.00	1,650.00
Washer Sterilizer	1	20,000.00	20,000.00
Warming Cabinet	1	4,000.00	4,000.00
Portable Ultrasound	1	12,000.00	12,000.00
Birthchair/Child Bearing Bed	6	7,000.00	42,000.00
PH Monitor	1	6,000.00	6,000.00
Pocket Dopler	2	500.00	1,000.00
Antepartum Fetal Monitor	1	12,000.00	12,000.00
Fetal Monitor Labor Room	3	11,160.00	33,480.00
Central System			20,885.00
220 PH System	1	5,500.00	5,500.00
Ultrasound Scanner	1	19,000.00	19,000.00
Intubator Infant	2	6,500.00	13,000.00
Incubator Infant, Transport	1	6,300.00	6,300.00
Neonatal Intensive Care Center	1	15,000.00	15,000.00
Hospital Call System	6	5,200.00	31,200.00
Monitor Oxygen	1	1,100.00	1,100.00
Monitor Respiration System	1	8,600.00	8,600.00
Heating Unit Free Standing	1	4,000.00	4,000.00
Suction Apparatus	1	400.00	400.00
Stool, Adjustable	5	350.00	1,750.00
Bassinet Warning Cart	2	3,500.00	7,000.00
Bassinet Warming w/Cabinet	16	450.00	7,200.00
Crash Cart, 5 Drawer	1	850.00	850.00
Cabinet Surgical Instrument	1	900.00	900.00
Cabinet Medicine	1	660.00	660.00
Cart Chart	1	300.00	300.00
Light Surgical Floor	2	800.00	1,600.00
Table, Exam	1	1,200.00	1,200.00
Light, Bilirubin	1	2,500.00	2,500.00
Bilimeter	1	1,200.00	1,200.00
		GRAND TOTAL	$383,575.00

population. Pediatric inpatient services were not routinely provided at Kenner Army Community Hospital. Acutely ill or uncomplicated orthopedic patients were periodically admitted to the hospital. Increased requirements for inpatient pediatrics would require examination and estimation of obstetrical services were to be re-established in the hospital.

Civilian Health and Medical Program of the Uniformed Services Maternity Care Provisions

Civilian Health and Medical Program of the Uniformed Services maternity care benefits begin when the beneficiary becomes pregnant, continues through delivery and up to the first six weeks after the baby is born.[1] Maternity care is defined as care needed due to pregnancy including complications from pregnancy. Treatment of nonpregnancy related conditions such as a broken leg are not covered under Civilian Health and Medical Program of the Uniformed Services maternity care benefits. Civilian Health and Medical Program of the Uniformed Services maternity care costs are cost shared by the beneficiary. The amount is determined by the frequency of care, the status of the beneficiary, and whether the baby is delivered in an inpatient or outpatient setting.

All women eligible for Civilian Health and Medical Program of the Uniformed Services benefits are eligible for maternity care under Civilian Health and Medical Program of the Uniformed Services. This includes spouses and unmarried children of active duty members, retirees, spouses of retirees and their unmarried children and the spouses and unmarried children of deceased active duty and retired service members.

Special provisions of the Civilian Health and Medical Program of the Uniformed Services program should be understood prior to utilization of maternity benefits to avoid

nonreimbursement of services or other cost sharing dilemmas. Circumstances may require more than one pregnancy-related admission during the maternity birth episode. In this case, all admissions are considered to be a single admission for cost-sharing purposes, regardless of the number of days between admissions, even when the beneficiary is admitted to more than one hospital.[2] Only Civilian Health and Medical Program of the Uniformed Services-approved birthing centers can be utilized when Civilian Health and Medical Program of the Uniformed Services "cost shares" the delivery and maternity care fees on an inpatient basis. Although military health care facilities are not permitted to refer patients to a particular organization, some hospitals provide listings of supplemental health insurance plans to assist beneficiaries who must fulfill "cost sharing" requirements (Appendix Q). Beneficiaries planning to deliver at home must receive a Nonavailability Statement prior to going to the hospital if home delivery complications arise. Prescription drugs related to the maternity episode are payable on an inpatient or outpatient basis depending on the status of the patient at the time of delivery or other termination of pregnancy (e.g., miscarriage). However, prescription drugs provided on an outpatient basis which are not directly related to the obstetrical care would be "cost shared" on an outpatient basis even though administered during the maternity episode.[3] Under normal circumstances no separate "cost share" would be collected for the newborn as the newborn is not considered a separate admission, but is included in the mother's admission. Problems are created in some states which have reimbursement programs which require hospitals to bill newborn charges separately from the mother's charge.[4] The Civilian Health and Medical Program of the Uniformed Services permits processing of the bill with special attention paid to ensure no duplication of the mother's charges or fees beyond the care received during the mother's admission.

Comparison of Civilian Health and Medical Program of the Uniformed Services and Joint Health Benefits Delivery Program Obstetrical Service Costs

Obstetrical services for fiscal year 1984 were provided at a Civilian Health and Medical Program of the Uniformed Service calculated cost of $1,396,601. The cost included inpatient hospital services, inpatient professional services, outpatient professional services and outpatient care "cost shared" as an inpatient. Total government and patient cost for inpatient services was $1,381,276. Outpatient services were provided at a cost of $15,325 (Appendix M). Inpatient services provide the greatest opportunity for overall cost savings under the Joint Health Benefits Delivery Program. The following represents a comparison of the Civilian Health and Medical Program of the Uniformed Service and calculated Joint Health Benefits Delivery Program obstetrical service costs for inpatient services:

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES OBSTETRICS CHARGES

	1984 Obstetrics	1984 Beneficiaries	1985 Obstetrics	1985 Beneficiaries
Total Inpatient Hospital Services	$958,242	411	1,014,532	412
Inpatient Hospital Services Government Cost	907,279		941,168	
Inpatient Hospital Services Patient Cost	50,963		73,364	
Average Length of Stay (Days)	4.40		3.86	
Total Occupied Bed Days	1,959		1,764	

Total Inpatient Professional Services Cost	423,035	469,563
Total Government Cost	409,196	442,165
Total Patient Cost	13,839	27,398

Kenner Army Community Hospital Joint Health Benefits Delivery Program Cost

Kenner Army Community Hospital cost applied to the Civilian Health and Medical Program of the Uniformed Services Inpatient Hospital Services Government Cost for fiscal year 1984 and $1,014,532, for Fiscal year 1985.

Occupied Bed Days for 411 maternity patients	1,959
Cost per bed day for fiscal year 1984	250.51
	490,749.09

$958.212. - $490,749.09 = $467,462.91 (Savings Potential)

Occupied bed days for 412 maternity patients	1,764
Cost per bed day for fiscal year 1985	198.35
	$349,889.40

$1,014,532. - $349,889.40 = $664,642.60 (Savings Potential)

A potential savings of over one million dollars was reflected in the comparison of Kenner Army Community Hospital and Civilian Health and Medical Program of the Uniformed Services costs. An average cost per bed rate was utilized to estimate the cost of services provided at Kenner Army Community Hospital. Again, the military's cost accounting policies do not distinguish patient charges by diagnosis as do civilian medical treatment facilities. Inpatient professional hospital obstetrical services were provided at a fiscal year 1984 Civilian Health and Medical Program of the Uniformed Services cost of $958,212.00 and a 1985 cost of $1,014,532.00. The significant difference in Civilian Health

and Medical Program of the Uniformed Services and Kenner Army Community Hospital costs may be partially attributed to several factors, one of which was the absence of the advantage derived from Civilian Health and Medical Program of the Uniformed Services negotiated professional fee schedule with providers contracted under the Joint Health Benefits Delivery Program. As previously discussed, charges received for care provided in a military medical treatment facility would not include ancillary service fees, annual deductibles, or supply costs. Additional savings could be realized for inpatient professional services based on decreased provider overhead. The $25.00 minimum fee would be avoided when care is provided in a military treatment facility. Civilian Health and Medical Program of the Uniformed Services charges reflected in fiscal years 1984 and 1985 Health Care Summaries include an annual deductible and minimum fee charge (Appendix M and N).

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[1]U.S., Department of Defense, CHAMPUS Maternity Care, CHAMPUS FS-8, Aurora, Colorado, 1985, pp. 1-4.

[2]Ibid., p.2.

[3]Ibid., p.3.

[4]Ibid., p.4.

V. CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES REFORM INITIATIVES

Although the emphasis of the feasibility study was to determine whether obstetrical or psychiatric services should be recommended for implementation under the Joint Health Benefits Delivery Program utilizing fiscal years 1984-1985, a realistic recommendation could not be made without a discussion of external factors which would significantly affect the recommendations. Since the Joint Health Benefits Delivery Program operates under the Civilian Health and Medical Program of the Uniformed Services regulation, Civilian Health and Medical Program of the Uniformed Services' reform initiatives represent a critical external factor that should be considered as a realistic part of the feasibility study.

The Civilian Health and Medical Program of the Uniformed Service reform initiative is designed to address several serious problems in the military health services system. Currently, the Civilian Health and Medical Program of the Uniformed Services program is too complex and too costly, both for the government and for beneficiaries. The primary mission of the military health services system is to be ready to care for active duty forces in time of war. In peacetime, the system provides health care to 2.2 million active duty members and 7.6 million dependents, retired members, their families and survivors.[1] Military medical facilties handle one million admissions and fifty million outpatient visits per year. In addition to its 168 hospitals and over 300 medical clinics, the Department of Defense (DoD) operates Civilian Health and Medical Program of the Uniformed Services which pays for a portion of the care with beneficiary "cost sharing" provisions. Now operated as a fee-for service program, Civilian Health and Medical

Program of the Uniformed Services is estimated to cost 1.5 billion dollars in fiscal year 1986.[2] Many military hospitals are overloaded, particularly for outpatient care, causing long delays in obtaining appointments even with the introduction of new programs such as the Joint Health Benefits Delivery Program. Reform plans aim to address these problems by adopting innovations like those that have made private sector health programs less costly and complex, such as health maintenance organizations and preferred provider organizations.[3] Substantially increasing access to free primary care outpatient care, reducing beneficiary cost sharing amounts, control of government costs, and increasing the ability of military hospitals to provide specialty and inpatient services, particularly those related to wartime medical and surgical specialty needs, are also Civilian Health and Medical Program of the Uniformed Service reform objectives.

Reduction of Beneficiary Costs Under Civilian Health and Medical Program of the Uniformed Services

The Civilian Health and Medical Program of the Uniformed Services' program currently operates as a bill-paying agency. It has made no attempt to use its nationwide buying power for the advantage of DoD beneficiaries, as is the practice in many private sector health care agencies and the Army Medical Department's supply system.[4] As a result, Civilian Health and Medical Program of the Uniformed Services costs have risen faster than private sector health care costs and DoD beneficiaries who receive care in the civilian community must frequently pay substantial out-of-pocket costs under the copayment requirements of the program. Department of Defense is now seeking to use its nationwide buying power by establishing three regional contracts covering the United States. Current planning is focused on awarding three regional contracts covering the entire United States under which competitively selected contractors would assume the

financial risk for any care provided to non-active duty beneficiaries in the civilian sector. For a fixed sum, the contractors would become responsible for paying for health care received by Department of Defense beneficiaries from civilian sector providers. This arrangement differs from the Joint Health Benefits Delivery Program in that the Joint Health Benefits Delivery Program is a fee-for-service program and the Civilian Health and Medical Program of the Uniformed Services reform initiative proposes a more cost effective capitation based program. Because the contracts would be financially at risk for care provided in the civilian sector they should have the incentive to organize high quality, cost effective civilian hospitals and physicians into preferred provider networks, with an emphasis on primary care that will offer services to Department of Defense beneficiaries at reduced costs. Specific quality of care requirements that are not presently possible under the current Civilian Health and Medical Program of the Uniformed Services regulations would also be a part of the contract with the "at risk" contractor. Contracts will not be required to be awarded on the basis of low bid. Civilian Health and Medical Program of the Uniformed Service program savings that can be gained by adopting cost-effectiveness reforms that have worked in the civilian sector will be returned to beneficiaries in the form of reduced Civilian Health and Medical Program of the Uniformed Services copayment requirements.[5]

Increase Access to Primary Care

Among the most significant improvements for beneficiaries that may be made possible by adoption of Civilian Health and Medical Program of the Uniformed Services reforms is increased access to primary care. Currently, a leading source of beneficiary dissatisfaction are the long delays experienced in obtaining appointments at military

health treatment facilities. Civilian Health and Medical Program of the Uniformed Services reform plans to address the access issue by requiring the contractor to establish free primary care centers to Department of Defense beneficiaries throughout the United States. Medical specialties that are planned for the centers include, but are not limited to, pediatrics, gynecology, internal medicine and family practice. Services not presently paid by Civilian Health and Medical Program of the Uniformed Services, such as routine physical examinations and preventive care, are also included in the reform package. Once established, the primary care centers will also serve as centers for referral of beneficiaries who require specialty services or inpatient treatment to military hospitals, or to civilian hospitals if care is not available. Patients would only be referred to those civilian hospitals that are part of the regional contractor's preferred provider network unless the service is unavailable. Preferred provider network facilities would offer services to beneficiaries at a reduced cost.[6]

Increased Access to Military Hospitals for Inpatient Care

The proposed Civilian Health and Medical Program of the Uniformed Services reform initiatives is expected to assist military hospitals in taking steps to increase the availability of inpatient care.[7] Beneficiaries must now obtain expensive specialty and inpatient services in the civilian community and comply with copayment requirements. The copayment requirements of the Joint Health Benefits Delivery Program are not as extensive, but can still represent an appreciable amount for beneficiaries. Reduction of the demand for primary care at military should allow the shifting of personnel to inpatient or other services. In addition, the regional contractor would be required to supplement military staff by supplying civilian physicians to the military hospital when needed to meet the demand for specialty care and inpatient services.

Overall Outcome and Impact of the Civilian Health and Medical Program of the Uniformed Services Reform Plan on the Joint Health Benefits Delivery Program

Although the simplification of Civilian Health and Medical Program of the Uniformed Services procedures has been attempted previously no favorable results have been realized according to the administrators of the Civilian Health and Medical Program of the Uniformed Services and Department of Defense.[8] The current system is complicated and time-consuming. It requires beneficiaries to pay physicians directly or with supplemental care policies prior to seeking Civilian Health and Medical Program of the Uniformed Services reimbursement, only to experience burdensome delays (Appendix R). Under the proposed system, physicians in the preferred provider network would not require beneficiaries to process claims or make substantial prepay or copayments.

According to the Civilian Health and Medical Program of the Uniformed Services, requirements are likely to include no reduction in the current Civilian Health and Medical Program of the Uniformed Services benefits package; reduced out-of-pocket expenditures by beneficiaries; preservation of beneficiary freedom to select other than the preferred provider without reduced copayments; assumption by the contractor of current Civilian Health and Medical Program of the Uniformed Service fiscal intermediary functions; acceptance of quality assurance standards and credentialing procedures; and staff sharing arrangements to maximize efficiency in both military and preferred provider facilities.

The reduction of serious deficiencies in medical readiness is another outcome that is expected upon the execution of the reform plan. Currently, only about one-third of the surgeons needed to care for combat casualties are in the Department of Defense health care system. Improved and increased use of civilian physicians and other medical personnel should assist in assuring that the necessary priority is given to acquiring the

appropriate numbers of military medical personnel in the specialties that would be needed to improve wartime readiness. Improved access for beneficiaries during peacetime should also be realized as sources of care both in the military and civilian community increase.[9]

Currently, about 70-75% of all Department of Defense beneficiary care is provided in military facilities and about 25-30% in the Civilian Health and Medical Program of the Uniformed Services funded civilian sector.[10] Even with the implementation of Civilian Health and Medical Program of the Uniformed Services reform initiatives the Department of Defense does not anticipate a substantial change in this ratio. Regional contracts will be undertaken in strict accordance with federal procurement regulations. Anticipated implementation of regional contracts is October 1987.

The effect of the Civilian Health and Medical Program of the Uniformed Service proposal on the Joint Health Benefits Delivery Program is not known, although several outcomes can be anticipated. Since more beneficiaries would be seen by civilian practitioners and hospitals that are members of the preferred provider network and the contractor would may be required to augment the medical staff in military health treatment facilities, the benefits of operating a Joint Health Benefits Delivery Program may be considered negligible. Some benefit of implementing a Joint Health Benefits Delivery Program could be the by-product for commands that are attuned to the medical needs of their beneficiaries and the shortfalls of the contractor through aggressive marketing of Joint Health Benefits Delivery Program services. Although primary care would be extensively provided via the contractor, the contractor would refer beneficiaries both military and civilian facilities for inpatient care.[11] The beneficiary would retain the right to make the decision concerning the facility to be utilized. Marketing the advantages of inpatient care in a military facility, particularly regarding free ancillary services and a nominal charge for meals, would be essential for any military hospital competing with the Civilian Health and Medical Program of the Uniformed Services regional contractor.

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[1]U.S., Department of Defense, Office of the Assistant Secretary of Defense for Health Affairs, Fact Sheet: CHAMPUS Reform Initiative, September 1985, p.3.

[2]Ibid., p.1.

[3]Joan B. Trauner, "The Second Generation of Selective Contracting: Another Look at PPOS," Journal of Ambulatory Care Management (May 1986): 13-17.

[4]U.S., Department of Defense, Office of the Assistant Secretary of Defense for Health Affairs, Fact Sheet: CHAMPUS Reform Initiative, September 1985, p.1.

[5]Ibid, pp. 2-3.

[6]Ibid, p.2.

[7]Ibid., p.3.

[8]Ibid., p.2.

[9]Ibid., pp. 2-3.

[10]Ibid., p.2.

[11]U.S., Department of the Army Headquarters, United States Army Health Services Command, Implementation of Joint Health Benefits Delivery Program, June 1984, pp. 4-5.

VI. CONCLUSION

Comparison of inpatient civilian facility and Kenner Army Community Hospital estimates indicated that utilization of the Joint Health Benefits Delivery Program as a mechanism for government cost savings would be a viable and cost effective option both for obstetrical and psychiatric services. First year obstetrical and psychiatric summary data reveal a difference in obstetrical and psychiatric service costs of $420,718.60 as reflected below, demonstrating the feasibility of establishing outpatient psychiatric services under the Joint Health Benefits Delivery Program versus obstetrical services.

Obstetrics Ward and Psychiatric Ward Total Cost (First Year)

Psychiatric Ward	
Staff	$452,960.40
Equipment	86,850.00
Renovation	6,704.00
Supplies	19,917.00
Nutrition Care (Food, Labor, Supplies)	29,552.00
Grand Total	$595,983.40

Obstetrics Ward

Staff	$583,310.00
Equipment	383,575.00
Supplies	20,817.00
Renovation	39,800.00
Nutrition Care (Food, Labor, Supplies)	34,200.00
Grand Total	$1,016,702.00

NOTE: Costs associated with relocation of current ward occupants were estimated as follows:

Relocation of NETS	$22,500
Modify Building 8151A*	11,000
Construct NETS/POT&S Storage area	10,000
Build Partition (relocate Exec Housekeeper)	1,500

*Cost based upon estimate of 250 square feet x $70/square foot.

VII. RECOMMENDATIONS

Although the results of the feasibility study indicate that the establishment of a Joint Health Benefits Program for psychiatric services would appear to be more cost effective than obstetrical services, doing neither is also a viable option. The administration of the program as it is currently organized is considered by the Civilian Health and Medical Program of the Uniformed Services, Civilian Health and Medical Program of the Uniformed Services fiscal intermediaries, Civilian Health and Medical Program of the Uniformed Services field representatives, health benefits advisors, and medical treatment facility Commanders as administratively burdensome, confusing and time consuming. As previously discussed, the fact that active duty personnel cannot be treated under the Joint Health Benefits Delivery Program is also considered a negative aspect of the program, particularly given the medical treatment facility Commander's priority mission to care for active duty service members. As mentioned in the Discussion chapter of this paper, events of the past year indicate that significant changes in the Civilian Health and Medical Program of the Uniformed Services program in general, and the Joint Health Benefits Delivery Program in particular, are soon to be directed by the Office of the Secretary of Defense for Health Affairs. Given the results of the feasibility study and nonmonetary considerations such as program participation eligibility, the following recommendations are presented for consideration:

- Ascertain the specifics of the Civilian Health and Medical Program of the Uniformed Services reform initiative prior to further implementation of services under the Joint Health Benefits Delivery Program. Civilian Health and Medical Program of the Uniformed Services reforms may reduce or curtail any current benefits of the Joint Health Benefits Delivery Program. Civilian Health and Medical Program of the Uniformed Services reforms could also make the implementation of the program more beneficial through administratve and eligibility reforms.

- In the event that the executive management of the Kenner Army Community Hospital deems it necessary to implement the program with or without Civilian Health and Medical Program of the Uniformed Services reform initiative information it is recommended they establish a Joint Health Benefits Delivery Program for psychiatric services. The following recommendations should facilitate the successful management of the program:

a. One department in the hospital should be designated as the primary contact for all Joint Health Benefits Program activities to insure that issues are addressed expeditiously and consistently, and to insure program continuity. Recommend that the Patient Administration Division serve as the overall program facilitator. The Division's Health Benefits Advisor should be designated to serve in this capacity. Joint Health Benefits Delivery Program provider and patient care issues should be coordinated by the Chief, Clinical Support Division.

b. Establish a committee to plan the conversion of the third floor area for inpatient psychiatry. The committee's responsibilities should include planning and coordinating facility modifications, staffing, equipment, relocation of current occupants, education and training.

c. Staffing of the Health Benefits Advisor's office should be commensurate with the level of responsibilities. The one individual currently assigned to accomplish all Civilian Health and Medical Program of the Uniformed Services related tasks is not enough, frequently resulting in documentation backlogs and patient counseling delays.

d. Expansion or revision of the quality assurance and credentialing programs is recommended to insure the appropriateness of allowing contracted Joint Health Benefits Delivery Program provider's privileges.

e. An extensive marketing program should be developed prior to the establishment of the service. The marketing program should include, at a minimum: (1) education of the staff, psychiatrists in the community, beneficiary population, and key base support activities such as the Directorate of Engineering and Housing and (2) dissemination of information relative to the program in the Civilian Health and Medical Program of the Uniformed Service office, via community forums, post and community newspapers, and the central appointments system.

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